Dept of Labor & Industries
Crime Victims Compensation
PO Box 44520
Olympia WA 98504-4520

# PROVIDER'S REQUEST FOR ADJUSTMENT

***Please type or print in dark ink***

DO NOT WRITE IN SPACE >

CHECK ONE →
- ☐ Total overpayment
- ☐ Partial overpayment
- ☐ Underpayment

## ENTER DATA FROM ORIGINAL REMITTANCE ADVICE

1) Claimant's name Last First M. Initial

4) Provider name and address

## INSTRUCTIONS APPEAR ON REVERSE SIDE

2) Claim number on remit advice

3) Correct claim number

5) ICN number on remittance advice

6) Provider number

7) Payee number

## COMPLETE ONLY THOSE LINE ITEMS PREVIOUSLY PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION

| 8) Line Item No | a) From/to Date of Service or Covered Dates | b) POS | c) TOS | d) Procedure Code/ Revenue Code/NDC | e) Code Mod | f) ICD-9-CM Diagnosis/ Side of body | g) Tooth No | h) Charge | i) Days/ Units/ Qty | j) Days supply | k) Description |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | | | | | | | | | | | |
| 02 | | | | | | | | | | | |
| 03 | | | | | | | | | | | |
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| 11 | | | | | | | | | | | |
| 12 | | | | | | | | | | | |
| 13 | | | | | | | | | | | |
| 14 | | | | | | | | | | | |

9) Other remarks/justification/special circumstances - attach required reports - explain fully

V - CLAIM NUMBER

Date | Phone number ( ) | Signature

F800-064-000 (PDF) provider's request for adjustment 2-00

RESET

# ADJUSTMENT REQUEST FORM

**THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:**

TOTAL OVERPAYMENT ----- Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating the ICN overpaid. Submit refunds to:

**Cashiers Office**
**Department of Labor and Industries**
**PO Box 44835**
**Olympia WA 98504-4835**

PARTIAL OVERPAYMENT --- A portion of the bill was overpaid. Complete Adjustment Request Form with correct information, including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT ---------- If a bill has been underpaid in error, the Adjustment Request Form must be completed with all pertinent information including date of service. Corrections or justification and/or reports must be included.

This form may **NOT** be used for:

Bills returned to you by the Department.
Totally denied bill. New bill must be submitted.

## INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

**Submit only one form for each ICN (Internal Control Number).**
**Attach a copy of remittance advice and original bill.**

1. **CLAIMANT'S NAME:** Clearly print claimant's full name.
2. **CLAIM NUMBER ON REMITTANCE ADVICE:** Enter the 7-digit number found in the Claim Number column on the remittance advice.
3. **CORRECT CLAIM NUMBER:** Claim number these services should be paid under.
4. **PROVIDER NAME AND ADDRESS:** Enter the name and address of the provider providing the service. Include telephone number.
5. **ICN NUMBER:** Enter the 17-digit number found in the ICN column to identify the bill submitted.
6. **PROVIDER NUMBER:** Enter the Crime Victims provider account number for the provider of service as it appears on the remittance advice.
7. **PAYEE NUMBER:** Enter the Crime Victims payee account number if payee was **different** than the provider of service.
8. **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
    a. **From/to Date of Service or Covered Dates:** Date of service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
    b. **Place of Service:** (POS) Two digit code identifying the place service was performed.
    c. **Type of Service:** (TOS) One digit code identifying the general type of service performed.
    d. **Procedure Code/Revenue Code/NDC:** Identify correct procedure, hospital service or national drug code.
    e. **Code Mod:** Modifier used to identify special circumstances for a service or procedure.
    f. **ICD-9-CM and DSM III or IV Diagnosis/Side of Body:** Enter appropriate diagnosis code for condition treated. Designate left or right side of body where applicable.
    g. **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
    h. **Charge:** Total of charges for services provided this line.
    i. **Days/Units/Quantity:** Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
    j. **Days Supply:** Total number of days a prescription is intended to cover.
    k. **Description:** Describe procedure or service.
9. **OTHER REMARKS / JUSTIFICATION / SPECIAL CIRCUMSTANCES:** Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.